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Memorandum

August 22, 2018

TO: Opioid and Other Substance Use Disorders Study Committee

FROM: Bill Zepernick, Principal Fiscal Analyst, 303-866-4777

SUBJECT: Additional Stakeholder Policy Recommendations

Overview

This memorandum presents additional policy recommendations submitted by stakeholders and interested persons for consideration by the Opioid and Other Substance Use Disorders Interim Study Committee. It is an addendum to the previous memorandum dated August 21, 2018. As noted previously, the full text of the stakeholder recommendations have been formatted by Legislative Council Staff to improve readability, correct typographical errors, and remove personal contact information, but are otherwise presented in their original, unedited form.

Submitted Policy Recommendations

Recommendations from Nancy Steinfurth, Liver Health Connections

1) When a person enrolls in Medication Assisted Therapy (MAT), the program is required to provide a complete physical exam, including a blood draw

    - We request that the Office of Behavioral Health require MAT programs to test for hepatitis C virus (HCV), hepatitis B virus (HBV) and HIV when someone enrolls in the programs - easily added to the draw; should include reflex testing; we currently offer antibody testing at 8 MAT programs; screening is not testing

    - All three diseases are on the rise in Colorado as a direct result of opioid and other substance use. New US HCV infections have nearly tripled in the past 5 years (CDC, 2017 data)

    - All three tests are recommended by HHS and U.S. Preventive Services Task Force (USPSTF) for persons with opioid or drug injection risk factors

    - Add hepatitis A and hepatitis B vaccination for all clients

2) SBIRT (Screening, Brief Intervention, Referral to Treatment) is a tool funded by SAMHSA and administered by Peer Assistance. It is used by Primary Care Physicians and others to gauge a variety of risks, including drug use

    - Some of the questions ask about recent drug use, but there's no follow-up to a positive response

    - We encourage SBIRT to add a recommendation that physicians offer HCV, HBV, and HIV tests to their clients who answer "yes" to the drug use question so that they can integrate infectious disease diagnosis into their practices

3) HCPF is putting together a proposal for 1115 waiver authority to add inpatient substance use treatment

    - We recommend they include testing for HCV, HBV, and HIV at intake in the proposal

    - Add hepatitis A and hepatitis B vaccination

    - And that they consider offering treatment at the same time if these clients had previously been tested; treatment will be covered by HCPF

4) Colorado's health department used to have CDC funding for viral hepatitis surveillance, but that funding ended in 2012; since then, CDPHE has been able to continue the program, but not in a comprehensive manner

    - For example, they perform case finding for acute hepatitis C test results (41 in 2016), but do not perform case finding for the over 4,865 chronic hepatitis C test results reported in 2016

- We recommend that CDPHE be given additional FTE to increase surveillance staff and additional funding to fill the positions

5) Every program that trains any provider - counselors, case managers, physicians, EMT, law enforcement, etc. - should include instruction about infectious diseases that may be transmitted during substance use

    - Especially training provided through the OBH SAMHSA-funded State Targeted Response to the Opioid Crisis Grant awarded in 2017

Recommendations from Colorado Association of Health Plans

The Colorado Association of Health Plans has a few ideas to present to the committee that we believe could help patients and those struggling with opioid addiction and dependence.

1) E-Prescribe Legislation

The Colorado Association of Health Plans (CAHP) supported HB18-1279 last year because it provides a safer method of prescribing controlled substances and decreases the likelihood of prescription tampering. It also makes it easier to detect practices who have a pattern of over-prescribing controlled substances and, when it becomes possible to configure it with the PDMP, it will make it harder for patients to doctor-shop.

2) Health Plan Access to PDMP

Health plans should be granted access to Prescription Drug Monitoring Programs (PDMP). Increased information, with appropriate privacy protections, supports the provision of holistic and integrated care. PDMP access would allow health plans to have a comprehensive history of a member's narcotic use so that plans can help create interventions and connect with providers regarding necessary treatment.

3) Naloxone

Naloxone is an incredibly important drug in the fight to save lives from opioid abuse and overdose. Unfortunately, it's in short supply and has become very expensive (according to this USA Today article, it has risen by 244 percent since 2006). Some states have found ways to purchase naloxone at a cheaper price through bulk negotiations and then allow municipalities to purchase it from the state (similar to how the Federal Government handles vaccines). Colorado should consider following suit and look into ways to decrease the price of this life-saving drug. For more detailed information on these options, please see this report from the NGA.

4) HIPAA Alignment

42 CFR Part 2 should be aligned with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of health care treatment, payment, and operations. CAHP believes that substance use disorder treatment records should align with HIPAA's treatment, payment, and healthcare operations provisions to allow the exchange of information, and deliver whole-person care.

5) MAT

As access to qualified substance use disorder treatment providers remains a barrier nationwide, CAHP encourages Colorado to dedicate more resources to ensure providers receive training in Medication Assisted Treatment (MAT). This training gives providers the necessary tools to guarantee patients receive services like mental health and substance-use disorder counseling to treat opioid-use disorder – rather than simply prescribing a medication. A bill could be modeled off of SB17-074 using what we have learned from that pilot program to expand training to a wider range of providers.

Recommendations from JK Costello

Hello, my name is JK Costello and I am a physician and health consultant. Thank you for organizing the interim study committee. It has been impactful and well-organized. Along with Denise Vincioni (cc'd here) of Denver Recovery Group, I authored a brief about medication-assisted treatment in jails. This brief was prepared at the request of the Colorado Rx Consortium's Treatment and Heroin Strategies workgroups as a way to inform legislators about the current state of MAT in Colorado jails, innovations around the country, and Colorado-specific recommendations for bills. I would appreciate it if you could pass this on to the members of the committee.

I understand that the request was for a single paragraph also. That is below. Thank you for your time.

Sincerely,
JK Costello, M.D., M.P.H.

Improving Treatment for Opioid Use Disorder in Jails and Prisons

To the chairperson and senators and representatives of the interim study committee, thank you for the opportunity to submit my idea. As I spoke about with Denise Vincioni at the August 14th meeting of the interim study committee, I believe that the most effective measure the committee could take is implementing medical treatment of opioid use disorders for incarcerated people. People who leave incarceration are 129 times more likely to overdose fatally within two weeks as members of the general public. Rhode Island's efforts to provide a range of medication-assisted treatments (MAT) to all prisoners resulted in a 65% drop in such fatal overdoses, leading to a 12% drop in overdoses statewide. If Colorado could duplicate Rhode Island's success, our state could save over 120 lives per year. In order to do this, some measures the legislature could take include:

- High-quality pilot studies for both methadone and buprenorphine product maintenance in areas where there is a critical mass of incarcerated individuals already receiving MAT and ready access to treatment after incarceration. These studies should include cost-effectiveness analyses.
- Incentives for jails and their medical providers to partner with local NTPs to deliver MAT doses for current NTP clients.
- Study use of MAT in drug courts and encourage drug courts to partner with MAT providers-- Indiana, New Jersey, and New York have taken this step
- Assessing long-term correctional facilities such as state prisons for induction of MAT, as this setting allows for induction, dose titrations, counseling, and thorough hand-offs prior to release.

Medication-Assisted Treatment in Jails and Prisons

Brief prepared for Colorado Rx Consortium Heroin Strategies and Treatment Workgroups

BACKGROUND

Incarceration is a turning point in the lives of many individuals with opioid use disorder (OUD). For many, it is the beginning of a cycle of incarceration and release; a full one-third of people with OUD are estimated to be incarcerated each year. During this cycle, they rack up legal charges that make gainful employment more difficult and decrease the chances of exiting this cycle. Unfortunately, for many people this cycle has an even more permanent end, death by overdose. People leaving incarceration are 129 times more likely to die during the two weeks after release than the general public.[1] This means that a disproportionate number of people—20% in one recent study[2]— who fatally overdose have been incarcerated in the last year. Decreasing overdose rates for this population can materially improve the overdose rate of an entire state.

Medication-assisted treatment (MAT) is the gold standard for treatment of opioid use disorder. MAT consists of one of three FDA-approved medications for OUD, including methadone, buprenorphine, and naltrexone. To date, there are no other physiological or pharmacological treatments that come close to MAT's effectiveness in reducing opioid abuse and overdose death. Availability of buprenorphine and methadone have been shown to decrease overdose deaths by half.[3] Nearly as significantly, these medications help people improve their level of functioning and decrease their risk of contracting HIV or hepatitis C.

Historically, patients that are maintained on MAT, specifically methadone and buprenorphine products, are tapered off these medications upon incarceration. Some are even discontinued without tapering, creating high risk of withdrawal symptoms including nausea, vomiting, and, at times, death. This brief is intended to outline the most common barriers to access across the state and detail programs around the nation and the globe which are surmounting these barriers. The hope is that by outlining these specific barriers and paths to success, we can create change across the system so that patients do not overdose or leave and return to the addictive cycle upon release.

STATE OF COLORADO

Currently, only two correctional facilities in Colorado maintain patients on their MAT. Denver Jail is able to do this because they are affiliated with Denver Health Hospital, which has a Narcotic Treatment Program (NTP, often known colloquially as a methadone clinic) located on site. There is a process in place that was put together by Denver Health and Office of Behavioral Health (formerly ADAD) over 15 plus years ago. When a patient on methadone goes to jail, the nursing staff contacts Office of Behavioral Health, where the Central Registry is located, and verifies that the individual is on methadone and verifies what location. The jail then contacts the facility and calls them immediately to verify the dose. The dose is then dispensed from Denver Health NTP and hand delivered daily to the jail by the nursing staff. They dispense approximately 10,000 doses per year for incarcerated

[1]Binswanger, Ingrid A., et al. "Release from prison—a high risk of death for former inmates." *New England Journal of Medicine* 356.2 (2007): 157-165.

[2]Green TC, Clarke J, Brinkley-Rubinstein L, et al. Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System. *JAMA Psychiatry.* 2018;75(4):405–407. doi:10.1001/jamapsychiatry.2017.4614

[3]Schwartz RP, Gryczynski J, O'Grady KE, et al. Opioid agonist treatments and heroin overdose deaths in Baltimore, Maryland, 1995-2009. Am J Public Health2013;103:917-92

individuals. This is an unreimbursed service and historically has cost the Denver Health program thousands of dollars annually.

Last year, a project was created called the MAT Induction Project. ARTS (Addiction Research Treatment Services NTP) Drug Court patients worked to collaborate with Denver Health to induct an individual on methadone. The patient completes consent through the Denver Drug Court prior to the incarceration and the physician from Denver Health NTP comes to the jail and completes the physical and starts the individual on methadone. This can only be completed with individuals that do not have warrants in other counties and are only in jail for less than 7 days due to the rules around assessments. When the patient is sentenced to a different county, the individual runs the risk of being tapered off of their methadone, so in those circumstances, methadone is not induced.

Denver Health recently received grant funding from SB202 that will allows about 132 vials of extended-release naltrexone, or Vivitrol, to be dispensed to patients that meet the criteria in the Denver County Jail that will be implemented November 2017. In addition, they will maintain patients also on their Suboxone if they are not going to be tapered when transferred to other counties that will in fact taper them off their medication and if they are, and are incarcerated while on Suboxone, then they will start a Suboxone taper for them. This medication is going to be paid for out of grant money. There are plans for the jail itself to be an NTP at some point.

Arapahoe County recently started a groundbreaking program in conjunction with three local NTPs to provide MAT to inmates at their jail. Completed and executed in July 2018, this agreement allows any inmate who is receiving treatment at a nearby NTP to continue their medication including all three FDA-approved drug types. This arrangement is the first of its type in Colorado and most resembles the form that MAT in jails would take in other counties. The patient has their medication delivered to them for the length of their stay.

Outside these two counties—for instance, in Boulder— patients must have their medication delivered daily from their NTP program. This is a non-reimbursable service. Buprenorphine/naloxone (trade name Suboxone) at this time is not allowed due to the county's bad experience with it in the past; many counties report that this daily delivery of medications is not always feasible due to patient numbers, distance, and other barriers to be elucidated later.

While other counties have gone to great lengths to provide inmates with MAT, no counties other than Arapahoe and Denver have a coordinated program to ensure that inmates can continue their medication. Furthermore, no counties except Denver have any provision to induct inmates onto these medications—a measure that can save lives and help inmates with a fresh start. With few exceptions including pregnant women in some areas, other patients in Colorado must be tapered off MAT. In areas where there are no methadone programs available, patients may go through significant withdrawal when they go to jail. Often, this results in serious consequences for the inmates and liability for the jails.

In Fremont County and others, many inmates are withdrawn from their controlled meds. There is, in fact, a pending lawsuit filed by the family of a man who died there in custody. He perished 17 days

after he was abruptly discontinued from his prescribed methadone and clonazepam. The cause of death was determined to be acute benzodiazepene withdrawal.[4]

It is clear from these examples that there are many disparate ways that correctional facilities deal with clients with opioid use disorder. Some of these do their best to be evidence-based, while others provide care that is frankly dangerous. Clearly, though, the state could use more standardized and humane methods for dealing with incarcerated clients with opioid use disorder. This is particularly true for a group of inmates at highest risk for complications, pregnant women.

Pregnant women are an especially vulnerable population when they are incarcerated and have a severe opioid use disorder. This is particularly true for clients on MAT. The fetus is at risk for miscarriage when they are forced into opioid withdrawal. Most jails do not have effective protocols for pregnant women with opioid use disorder. Some end up doing very dangerous things. For example, patients in some counties are given opiates, such as codeine or long-acting morphine, to alleviate withdrawal. However, this inadvertently continues the addictive cycle. In addition, these women are at risk of immediate relapse, overdose, hepatitis C infection, or endocarditis in pregnancy. These are extremely severe and completely avoidable consequences of interruption of MAT.

Denying MAT to pregnant women during incarceration causes risk not only to the mother but also the baby. While there are financial barriers to correctional facilities providing MAT, the overall society cost of discontinuing these medications is far higher. Many women are forced into a taper and end up in the hospital with early contractions or other severe symptoms affecting the mom and the fetus. In fact, in 2017, Denver Health recently had three pregnant clients present from jail in withdrawal in just a three-week period.

BARRIERS:

Many of the barriers to MAT in jails and prisons fall into these categories:

a. DEA Regulations for NTPs[5]. Per federal statutes, the only way that jails and prisons can dispense methadone is either by daily delivery from an NTP or becoming an NTP themselves

b. Correctional institution policy

    1. Pre-existing clause: Colorado state law allows counties to charge inmates for treatment of any pre-existing condition

    2. Difficulty with storing/administering medications

c. Funding and payment structures

    1. Correctional facilities unable/unwilling to pay for medications

[4]Harmon, T. "Former Fremont Sheriff's Captain Speaks Out About Jail Death." *Pueblo Chieftain* January 11, 2017. http://www.chieftain.com/news/top/former-fremont-sheriff-s-captain-speaks-out-about-jail-death/article_dabf5633-6539-5379-a7cf-94285ed1c667.html

[5]https://www.deadiversion.usdoj.gov/21cfr/21usc/823.htm

2. Medicaid does not cover incarcerated patients
3. Grant funding does not reach all counties
4. Money that is available is used at the discretion of the jail; patients are still tapered even when not necessary
5. Money distributed from JBBS/STR grant/SOR grant is not used for methadone or the transportation of the patient or the program requiring the program to deliver methadone with no reimbursement for that service or medication

d. Stigma/Misinformation: "Substituting One Drug for Another"

e. Organizational Culture

f. Lack of knowledge of MAT and addiction by providers and administrators

g. Access to methadone: 64 counties and only 24 NTPs

1. Transfer of the medication from NTP to the jail is not feasible in rural areas
2. Many of the jails do not allow methadone unless the women are pregnant

h. Provider Training: Lack of providers who have a DATA Waiver

Creating Successful Transitions

Despite the barriers outlined above, there are some jails and prisons across the country successfully engaging inmates in medication-assisted treatment.[6] This portion of the brief is intended to show that these barriers can be and have been overcome in cities and states with the desire to treat inmates humanely and increase their chances of survival and success upon release.

As stated above, it is imperative that correctional facilities provide MAT to inmates because the links between incarceration and opioid dependence are so strong. Over 15% of individuals who enter America's jails and prisons are dependent on opioids.[7]

There is a proven solution to these problems. Providing MAT for inmates— even if only for a brief period—and connecting them with MAT upon release has been shown to reduce overdoses, opioid use, and other criminal behavior. A meta-analysis of prison-based MAT programs showed that "evaluations of prison-based programs have consistently yielded positive results."[8]

Rikers Island, in New York City, has provided methadone for opioid-dependent inmates for over 20 years. The facility treats over 18,000 detoxification clients each year and refers many of those released to community-based NTPs.[9]

Connecticut recently started a pilot program through two of its state prisons to provide methadone to about 50 inmates who were engaged in MAT prior to incarceration; they are looking to expand this

[6]Nunn, A., Zaller, N., Dickman, S., Trimbur, C., Nijhawan, A., & Rich, J. D. (2009). Methadone and buprenorphine prescribing and referral practices In US prison systems: Results from a nationwide survey. Drug and Alcohol Dependence, 105(1–2), 83-88.

[7]U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National survey on drug use and health, 2006.

[8]Jürgens, R., Kerr, T. (2004) Methadone maintenance therapy in prisons: reviewing the evidence. Canadian HIV/AIDS Legal Network

[9]Fallon, B. M. (2001). The Key Extended Entry Program (KEEP): from the community side of the bridge. *The Mount Sinai journal of medicine, New York*, *68*(1), 21-27.

program due to its success. It has resulted in higher levels of staff satisfaction and very few adverse incidents. Furthermore, the program has been administered equitably, with the racial and ethnic makeups of the MAT pilot program very similar to those of the prison's population.[10,11] By expanding statewide, Connecticut will likely be the second state prison system to offer MAT to a large cross-section of inmates. The state expects to spend $4 million per year on opioid treatment in jails and prisons.

Rhode Island, in the largest study of the effectiveness of MAT in jails, began in 2017 offering medications for OUD to all inmates at a cost of $2 million per year for the entire state. This project has been very successful at reducing opioid overdoses after release; in its first six months, opioid overdoses in people with recent incarceration dropped by 65%. In fact, the entire state's overdose rate dropped by 12% during this period, largely driven by the reduction in overdoses by people recently released.

A large 2016 meta-analysis of treatment outcomes after incarceration showed a few clear differentiating factors in continuation of treatment after release.

- Inmates who receive MAT prior to release are far more likely to follow up for treatment in the community; virtually every study in the analysis agreed with this finding.
- Receiving MAT prior to release benefits both inmates continued on MAT as well as those who have already gone through withdrawal while incarcerated.
- MAT while incarcerated is of little value if there are no provisions for post-release follow-up.
- There is little data to compare options for MAT (i.e. methadone vs buprenorphine) in a post-release setting.[12] It is ideal to allow clients and physicians to determine the best option.

RECOMMENDATIONS

It is the standard of care for inmates to continue on their prior medications while incarcerated. "However, this minimum standard is routinely violated in the US for opioid agonist treatment," states the author of the 2016 meta-analysis of MAT in correctional settings. While initiating inmates on MAT during incarceration would be ideal, this practice has significant barriers in the short-term, high-turnover setting of county jails; maintenance on current medications should thus be prioritized.

In Colorado, there are 24 NTPS that dispense methadone where the following jails could be impacted. These NTPs serve the areas where they can reach the patient. The following counties are served by these NTPs: Adams, Arapahoe, Alamosa, Pueblo, Weld, Denver, Boulder, Delta, Mesa, Durango, La Junta, Fort Collins, Jefferson, and El Paso. There are buprenorphine providers in all major cities as well as many outlying areas; a partial map of buprenorphine providers is available here.[13]

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[10]Collins, D. "Connecticut to expand methadone treatment in prisons." *New Haven Register* April 17, 2016. http://www.nhregister.com/connecticut/article/Connecticut-to-expand-methadone-treatment-in-11333029.php

[11]Maurer, K. "Opioid Addiction and Corrections." http://www.ct.gov/opm/lib/opm/cjppd/cjcjpac/20150430_cjpacpowerpoint_-methadone_presentation.pdf

[12]Sharma, A., O'Grady, K. E., Kelly, S. M., Gryczynski, J., Mitchell, S. G., & Schwartz, R. P. (2016). Pharmacotherapy for opioid dependence in jails and prisons: research review update and future directions. *Substance Abuse and Rehabilitation*, *7*, 27–40. http://doi.org/10.2147/SAR.S81602

[13]Colorado Health Institute, "Miles Away from Help." https://www.coloradohealthinstitute.org/research/miles-away-help

Note: This brief was authored by Denise Vincioni LPC, CAC III (Denver Recovery Group) and JK Costelo MD, MPH (Steadman Group). Angela Bonaguidi (ARTS), Dr. Kaylie Klie (Denver Health), Carl Anderson (Arapahoe County), Dr. Joshua Blum (Denver Health), Dr. Lesley Brooks (Northern Colorado Health Alliance/Sunshine Clinic), Dr. Mike Neremberg (Pueblo Public Health/Crossroads, and Dr. Sasha Rai (Denver Health) also assisted in its preparation.

In order to align standards of care with accepted norms, and to decrease the likelihood of recidivism and overdose in recently released individuals dependent on opioids, we recommend the Legislature and counties take the following actions:

- High-quality pilot studies for both methadone and buprenorphine product maintenance in areas where there is a critical mass of incarcerated individuals already receiving MAT and ready access to treatment after incarceration. These studies should include cost-effectiveness analyses.
- Incentives for jails and their medical providers to partner with local NTPs to deliver MAT doses for current NTP clients.
- Ensuring that all inmates with opioid use disorder are provided with naloxone and education upon release.
- Warm referral to appropriate, locally available MAT for individuals who entered the correctional system dependent on opioids, regardless of whether they receive MAT while incarcerated. This should include assistance with Medicaid enrollment.
- Utilize contracting language to promote uptake of MAT by health care providers in correctional settings, requiring an assessment of opioid dependence upon incarceration and a demonstration that health care providers are making a good faith effort to provide MAT to inmates dependent on opioids, particularly pregnant women.
- Assessing long-term correctional facilities such as state prisons for induction of MAT, as this setting allows for induction, dose titrations, counseling, and thorough hand-offs prior to release.
- Utilization of programs that provide free and reduced cost intramuscular naltrexone prior to release for inmates outside the catchment areas of NTPs.
- Study use of MAT in drug courts and encourage drug courts to partner with MAT providers
- Link MAT funding with actual provision of medications—the gold standard for treatment of opioid use disorder— rather than adjunct services.

Recommendations from Jessica Eady, Colorado Consortium for Prescription Drug Abuse Prevention

Suggestions to Improve Behavioral Health Care

Given the ongoing behavioral health workforce shortage and the varying levels of quality among existing treatment options, several suggestions have been proposed to increase access and quality of care for individuals with SUDs. Building upon the legislative success of last year's loan repayment program, some stakeholders have proposed to expand incentives/benefits to LAC and CAC professionals to encourage more students to pursue this career choice. To this end, specific support should be provided for individuals who have entered long-term recovery from a SUD and are interested in serving as case managers, peer specialists, or clinicians. Other stakeholders have requested that billable hours for existing behavioral health clinicians be reimbursed to compensate for the lost productivity that an office incurs when clinicians take time off to attend trainings required to maintain a CAC/LAC. Additionally, rural advocates have voiced the need to ensure that reimbursement rates (and therefore, corresponding salary rates) for behavioral health clinicians located in rural areas be equal to that of urban areas. Currently, physicians and SUD clinicians relocate to the Front Range because they can earn significantly more money in urban counties compared to rural. Suggestions from both urban and rural counties have addressed the current structure of the MSO system, and asked for it to be examined by the legislature to ensure transparency and equity. As it currently stands, the possibility exists that someone who is making funding decisions as a MSO board member is also benefitting from those decisions as a SUD treatment provider. Lastly, both urban and rural county stakeholders have requested a patient advocate be placed into withdrawal management facilities and SUD treatment facilities to advocate for clients who may have received inadequate care but lack the resources to pursue a formal complaint on their own behalf. Each of these suggestions may be considered as examples of strategies to improve the capacity of the behavioral health care workforce to care for individuals with substance use disorders. Further information is provided on the list of suggestions from local communities.